WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

10600

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution 211 Springdale St

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 211 Springdale, St., (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME David J. Abbott

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22 - 1939

8. AGE: Years | Months 5 | Days 9 | If less than one day hrs. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Clarence Abbott

13. Birthplace Maryland

MOTHER 14. Maiden name Lola Hoffman

15. Birthplace Maryland

16. Informant Clarence Abbott

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 4-39 (month) (day) (year)

Cemetery or ~~crematory~~ Davis Memorial

Location R.F.D. 4 Cumberland Md

18. Funeral director V. L. Lamparam

Address Cumberland Md.

19. Nov. 3 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 1939, at 11.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 29 1939, to Nov. 2 1939, and that I last saw him alive on Nov. 2 1939.

Immediate cause of death Embrocolitis

Due to

Due to Whooping Cough

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION about Oct 15 - 39 about Oct 20 1939

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; no

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M E B Owens M. D. or other

Address 133 Va ave Date signed Nov. 8 '39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 8 193[illegible]
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10601

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:

County Allegany

City or town Little Orleans, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 7 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Little Orleans Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harriet Ethel Mellott Ashkettle

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Married.

B (b) Name of husband or wife Edward Ashkettle.

B(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1892.

8. AGE: Years 46 Months 10 Days 17 If less than one day hrs. min.

9. Birthplace Bucks Valley, Fulton Co, Pa.

(Town, county, and state)

10. Usual occupation House work

11. Industry or business at Home

FATHER

12. Name Daniel A Mellott.

13. Birthplace Unknown

MOTHER

14. Maiden name Katherine True

15. Birthplace Bucks Valley, Pa.

16. Informant Edward Ashkettle.

Address Little Orleans, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 15, 1939. (month) (day) (year)

Cemetery or crematory Methodist Cemetery

Location Bucks Valley Pa

18. Funeral director Jacob Haller.

Address Cumberland, Md.

19. Nov 13 1939 T. T. Mann (Per) M E Mann Dep Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1939, at 4:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 12 1939, to Nov. 12 1939, and that I last saw her alive on Nov. 12 1939.

Immediate cause of death Angina pectoris

DURATION 1/2 hour.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Watson, M.D. M. D. or other

Address Little Orleans, Md. Date signed Nov. 13, 1939.

RECEIVED
DEC 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93c)

10602

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Lindnerville

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): ~~70~~ 79 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Lindnerville (If rural give LOCATION)

2(a) IF YETERAN, NAME WAR

3. (a) FULL NAME: Henry Baker

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1860

8. AGE: Years: 79 Months: ? Days: ? If less than one day ____ hrs. ____ min.

9. Birthplace: Cumberland, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Retired

FATHER: 12. Name: George Baker

13. Birthplace: Germany

MOTHER: 14. Maiden name: Christina Hauner

15. Birthplace: Germany

16. Informant: joseph Baker

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 22 39 (month) (day) (year)

Cemetery or crematory: St Peter x Paul

Location: Cumberland Md

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. Nov. 22, 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19th., about 1939, at 1 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death: Chronic Myocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: no autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Prince H. Corson M. D. (M. D. or other)

Address: Cumberland, Maryland Date signed: 11/19/39

Deputy Medical Examiner - Allegany Co.

RECEIVED
DEC 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

CERTIFICATE OF DEATH

10603

Reg. Dist. No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Little Orleans

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Little Orleans Rd.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Little Orleans Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Little Orleans Rd.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Samuel D. Barnes

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mrs. Sina Barnes

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 13, 1849.

8. AGE: Years	Months	Days	If less than one day
90	8	26	hrs. min.

9. Birthplace: Penna. (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business:

FATHER — 12. Name: Dawson Barnes

13. Birthplace: Penna.

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Mrs. Sina Barnes

Address: Little Orleans, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 16, 1939 (month) (day) (year)

Cemetery or crematory: Piney Grove Cem.

Location: Piney Grove Along Balti. Pike

18. Funeral director: J. C. Wolford

Address: Cumberland

19. Nov 14 1939 (Date rec'd by registrar) T. T. Mann (Dep) M E Mann Dept Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 13, 1939, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1937 to Nov. 13 1939, and that I last saw him alive on Oct. 10, 1939

Immediate cause of death	OURATION
Chronic Myocarditis	2½ yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. A. Watson M.D. M. D. or other

Address: Little Orleans Md. Date signed: Nov. 14 1939

RECEIVED
DEC 1 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (27) CB

10604

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State PENNSYLVANIA County BEDFORD ✓

City or town EVERETT Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
MRS. ESTELLA BIVENS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife HARVEY BIVENS

6(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) JUNE 1, 1891

8. AGE: Years	Months	Days	If less than one day
48	5	12	hrs. min.

9. Birthplace PENNSYLVANIA (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name GEORGE O. CLARK

13. Birthplace PENNSYLVANIA

MOTHER 14. Maiden name RACHEL NAURICE

15. Birthplace PENNSYLVANIA

16. Informant HARVEY BIVENS

Address EVERETT, PA.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 16, 1939 (month) (day) (year)

Cemetery or crematory Wells Valley Cem

Location Fulton Co. Penna

18. Funeral director Ross P. Valentine

Address Everett Pa.

19. Nov. 13 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 13, 1939 at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw her alive on Nov. 12 1939

Immediate cause of death: Post operative psychosis — DURATION: 4 days

Due to

Due to

Other conditions: Acute Cholecystitis

(Include pregnancy within 3 months of death)

Major findings: Of operations: Acute Cholecystitis

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W R Hodges M. D. or other

Address Cumberland, Md Date signed 11/13/39

DR. HAWKINS

RECEIVED
DEC 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93C)

10605

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: Allegany

County

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 107 East Fifth Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 107 East Fifth Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Oscar Blake

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rachael Lease

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.): Nov. 6, 1867

8. AGE: Years 71 Months 11 Days 28 If less than one day ___ hrs. ___ min.

9. Birthplace: Bloomington, Indiana
(Town, county, and state)

10. Usual occupation: Conductor

11. Industry or business: B. & O. Railroad

FATHER
12. Name: Charles Blake
13. Birthplace: Maine

MOTHER
14. Maiden name: Louise McLaughlin
15. Birthplace: Indiana

16. Informant: Mr. William E. Blake
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 6, 1939 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Nov. 4 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3/39 19 , at 1 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/3/39 19 , to 11/3/39 19 , and that I last saw him alive on 11/3/39 19 .

Immediate cause of death: Chronic Myocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard J. Williams M.D. M. D. or other

Address 34 Va. Ave., Cumberland, Md Date signed 11/3/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1939
REAU V. S.

WITHIN CORPORATE LIMITS

STATE OF MARYLAND—CERTIFICATE OF DEATH

10606

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Allegany — Registration Dist. No. 4

Village or City Cumberland Md — No. Allegany Hosp St., 4-1 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Miss Flora Boggs

(a) Residence: No. 415 Bedford St., Ward — S. Sec. No. 214-05-7048

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Single

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, and year) Oct 12-1900

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	38	—	26	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife Presser

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. At Home Footer's Dye Works

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Md

FATHER

13. NAME Loyal S. Boggs

14. BIRTHPLACE (city or town) (State or country) Md

MOTHER

15. MAIDEN NAME Naioma Stallings

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Wayne Boggs (Address) Cumberland Md

18. BURIAL, CREMATION, OR REMOVAL Place Rose Hill Cem Date Nov 10, 1939

19. UNDERTAKER U. L. Lenhart (Address) Cumberland, Md.

20. FILED Nov. 10, 1939 J. P. Franklin, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH 11 (Month) - 8 (Day), 1939 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Oct-24-39, 19__, to Nov-8, 1939

I last saw h__ alive on Nov-8, 39; death is said to have occurred on the data stated above, at 6 p.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Influenza Encephalitis	10-22-39

Othar **Contributory Causes** of importance:

Nama of operation None — Date of —

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicida? — Date of injury —, 19__

Whera did injury occur? (Specify city or town, county and State)

Specify whether injury occurrad in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or Injury in any way related to occupation of deceasad? No

If so, specify

(Signed) W. Alfred Van Ness M. D.

(Address) Cumberland, Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED DEC 6 1928 BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (160 B)

10607

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:
County Allegany
City or town Morantown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Morantown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Address Mt. Savage Md.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Thomas Booth

3. (b) Social Security Number

4. Sex M
5. Color or race W
6. (a) Single, married, widowed, or divorced S

B (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1939

8. AGE: Years | Months | Days 5 | If less than one day hrs. min.

9. Birthplace Morantown Allegany Md.
(Town, county, and state)
10. Usual occupation
11. Industry or business Infant
FATHER 12. Name William Henry Booth
13. Birthplace Maryland
MOTHER 14. Maiden name Maryland Skidmore E.
15. Birthplace Maryland
16. Informant William H Booth
Address Mt Savage Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 19-1939 (month) (day) (year)
Cemetery or crematory Cockhart Cemetery
Location Eckhart Md.
18. Funeral director ~~[illegible]~~ J. J. Durst
Address Frostburg Md.
19. 11/18 1939 (Date rec'd by registrar) H. J. Bostetter M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1939, at 8 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 14 1939, to Nov 18 1939, and that I last saw him alive on Nov 16 1939.
Immediate cause of death Convulsions — DURATION 4 days
Due to Compression of skull Brain Injury
Due to Difficult Labor
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. J. Bostetter M.D. M. D. or other
Address Mt Savage Md Date signed 11/18-1939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 4 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49-A)

10608

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 10 days

Stay in this community (yrs., or mos., or days): 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Westernport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mary Bothwell

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6 (b) Name of husband: Hugh

6(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): 1858

8. AGE: Years: 81 Months: Days: If less than one day: hrs. min.

9. Birthplace: County Clare, Ireland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Michael Lannon
13. Birthplace: Ireland

MOTHER
14. Maiden name: Honora Droney
15. Birthplace: Ireland

16. Informant: Mrs. Eugene Daly
Address: Washington, D.C.

17. Burial and Removal (Burial, cremation, or removal Which?) Date thereof: Nov. 29 1939 (month) (day) (year)

Cemetery or crematory: St. Peters Cem

Location: Westernport, Md.

18. Funeral director: D. S. Bowls
Address: Westernport

19. Nov. 29 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27 1939, at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 17 1939, to Nov 27 1939, and that I last saw her alive on Nov. 26 1939.

Immediate cause of death: Uremic Coma following

Due to: Carcinomatosis

Due to: original focus Carcinoma Et ovary

Other conditions: (Operation)
(Include pregnancy within 3 months of death)

Major findings:
Of operations: Carcinoma Et ovary & sigmoid c̄ Carcinomatosis

Of autopsy

DURATION: 1 day

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: L. M. Wilson Jr. M. D. or other

Address: Cumberland Md. Date signed: 11-27-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

10609

CERTIFICATE OF DEATH

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Dogwood Flat.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 1 day.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Garrett
City or town: nr Barton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.:
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Katherine Elizabeth Broadwater

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6 (b) Name of husband or wife: Joseph C. Broadwater
6(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Dec. 24. 1867.

8. AGE:

Years	Months	Days	If less than one day
71	10	29.	hrs. min.

9. Birthplace: Garrett Co. Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own Home
FATHER 12. Name: Christopher Miller
13. Birthplace: Garrett Co.
MOTHER 14. Maiden name: Jane Warnick
15. Birthplace: Garrett Co.
18. Informant: Mrs. Ruban Broadwater
Address: Barton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 27. 1939 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cemetery
Location: Morgan. Md.
18. Funeral director: David S. Boal.
Address: Barton, Md.
19. Nov. 25 1939 (Date rec'd by registrar) O. A. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 23. 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1937, to Nov. 23 1939, and that I last saw her alive on Nov 23 1939.

	DURATION
Immediate cause of death: Myocarditis	July 1939
Due to: Hypertension and	1931
Arteriosclerosis	1935
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide: No Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R E Berry M.D.
M. D. or other
Address: Piedmont W. Va. Date signed 11/23/39

RECEIVED
DEC 5 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

CP 10610

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND MD. (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 1 Day

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State WEST VIRGINIA County MINERAL

City or town FORT ASHBY Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME AMELIA LOUISE BROWN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	INFANT

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1939

8. AGE:

Years	Months	Days	If less than one day
9 MONTHS		9	hrs. min.

9. Birthplace MARYLAND (town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name ARNO BROWN

13. Birthplace WEST VIRGINIA

MOTHER 14. Maiden name FRANCES FRASE

15. Birthplace WEST VIRGINIA

16. Informant ARNO BROWN

Address FORT ASHBY, W.VA.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 12, 39 (month) (day) (year)

Cemetery or crematory Fort Ashby Cem.

Location Fort Ashby W. Va.

18. Funeral director J. C. Wolford

Address Cumberland

19. Nov. 11, 1939 (Date rec'd by registrar) J.P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 10, 1939 at 5:30 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 9 1939 to Nov 10 1939 and that I last saw h-e alive on Nov. 9 1939

Immediate cause of death	DURATION
Ileo Colitis	11-5-39
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H W Eliason M.D. M. D. or other

Address 126 Prospect St. Cumberland Date signed 11/10/39

DR. ELIASON

RECEIVED
DEC 6 1939
BUREAU V. S.

10611 9

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93C)

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 154 Wood St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Sarah B. Chidster

3. (b) Social Security Number: →

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Charles Chidster

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 12 1866

8. AGE:

Years	Months	Days	If less than one day
73	6	14	____ hrs. ____ min.

9. Birthplace: Borden Mines Allegany Md
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: —

FATHER
12. Name: Wm Williams
13. Birthplace: Wales

MOTHER
14. Maiden name: Sarah Williams
15. Birthplace: Wales

16. Informant: Stanley Chidster
Address: Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 30 1939 (month) (day) (year)

Cemetery or crematory: Cemetery Allegany

Location: Frostburg

18. Funeral director: J. J. Hurst
Address: Frostburg, Md

19. Nov 30 1939 (Date rec'd by registrar) Mrs. A. R. Haeka Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 28 1939, at 12:40 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 1935, to Nov 28 1939, and that I last saw her alive on Nov 27 1939.

Immediate cause of death: Chronic Myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: no

Of autopsy: no

DURATION: several years

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: W. O. McLane Jr. M.D.
M. D. or other

Address: Frostburg Md Date signed: Nov 28 1939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 2 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (91-a)

CERTIFICATE OF DEATH

10612

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 33 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County ALLEGANY
City or town CUMBERLAND Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 30 N. LIBERTY ST.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME CHILDERS, CALVIN MR.

3. (b) Social Security Number 217-10-6752

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
MALE	WHITE	~~SINGLE~~ Divorced

6 (b) Name of husband or wife Unknown
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Mar. 6, 1899.

8. AGE: Years	Months	Days	If less than one day
40	8	20	____ hrs. ____ min.

9. Birthplace W.VA. (Town, county, and state)
10. Usual occupation BARBER
11. Industry or business

FATHER
12. Name CHILDERS, FRANK
13. Birthplace W.VA.

MOTHER
14. Maiden name LORRETTA, LILLIAN
15. Birthplace W.VA.

16. Informant MEMORIAL HOSPITAL,
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 28, 1939 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland
18. Funeral director J. C. Wolford
Address Cumberland, Md.

19. Nov. 28, 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

DR. ELLASON

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1939, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 15 1939, to Nov. 26 1939 and that I last saw h[illegible] alive on Nov. 26 1939

Immediate cause of death	DURATION
Subacute Endocarditis	6 WK
Subacute Myocarditis	6 WK.
Due to Chronic infection in tonsils	3 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of ND
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE N. W. Ellason M. D. or other
Address 126 Green St. Cumberland Md. Date signed 11/28/39

RECEIVED
DEC 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1248

10613

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:
County Allegany
City or town Ellerslie, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Ellerslie Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Harriet Yost Clark

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Clarence L. Clark
6(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1875

8. AGE: Years	Months	Days	If less than one day
64	2	2	____ hrs. ____ min.

9. Birthplace Mineral, W.Va. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name James Yost
13. Birthplace Hampshire, W.Va.

MOTHER
14. Maiden name Rachel Umstot
15. Birthplace Mineral, W.Va.

16. Informant Clarence L. Clark
Address Ellerslie

17. Burial, 1939 (Burial, cremation, or removal. Which?) Date thereof Nov. 21, 1939 (month) (day) (year)
Cemetery or crematory Porter
Location Bedford County, Pa.
18. Funeral director Harvey H. Zeigler
Address Hyndman Pa.

19. Nov 20 1939 (Date rec'd by registrar) J. Lloyd Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1939, at 10:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 9 1939, to November 17 1939, and that I last saw her alive on November 17 1939.

Immediate cause of death Chronic Myocarditis DURATION
Chronic glomerular Nephritis

Due to

Due to

Other conditions Hypertention
Cirrhosis of the Liver.
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J Bayley Hunter MD M. D. or other
Address Cumberland Md Date signed 11/18/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 7 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-a)

CERTIFICATE OF DEATH

10614

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 105 Race Street
Stay in hospital or inst. (yrs., or mos., or days): 40 years
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 105 Race Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Christopher J. Codire

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed or divorced
Male	White	Married

6 (b) Name of husband or wife: Margaret King
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 19, 1870

8. AGE: Years: 69 | Months: 6 | Days: 30 | If less than one day: hrs. min.

9. Birthplace: Franklin, Maryland (Town, county, and state)
10. Usual occupation: Blacksmith
11. Industry or business: B. & O. R. R.

FATHER
12. Name: Peter Codire
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Clancey
15. Birthplace: Ireland

16. Informant: Mrs. Frank Kastner
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 21, 1939 (month) (day) (year)
Cemetery or crematory: St. Patrick Cemetery
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. Nov. 20, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 18 1939, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-11 1936, to Nov 18 1939, and that I last saw h[illegible] alive on Nov 18 1939.

Immediate cause of death	DURATION
Apoplexy	2 hrs
Due to Arterio sclerosis + Hypertension	2½ yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: P. C. Bowen M.D. M. D. or other
Address: Cumberland Md. Date signed: 11-18-39

RECEIVED
DEC 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-a)

10615

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany.

City or town Cumberland.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 106 East Oldtown Rd.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany.

City or town Cumberland. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 106 E. Oldtown Rd.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John William Conner

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Josephine B Brooks.

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb 20, 1859

8. AGE: Years 80 Months 8 Days 27 If less than one day ____ hrs. ____ min.

9. Birthplace: Winchester, Virginia
(Town, county, and state)

10. Usual occupation: Machinist.

11. Industry or business: Retired 9 yrs.

FATHER
12. Name: Geo Conner
13. Birthplace: Va.

MOTHER
14. Maiden name: Sydney Striker
15. Birthplace: Va.

16. Informant: Margaret Conner.

Address: 106 E. Oldtown Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 19 39 (month) (day) (year)

Cemetery or crematory: Winchester Va.

Location: " "

18. Funeral director: Louis Stein Inc

Address: Cumberland

19 Nov. 19 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1939, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 2 1939, to Nov. 18 1939, and that I last saw him alive on Nov. 18 1939.

Immediate cause of death: Arteriosclerosis — DURATION: 3 yr.

Due to: Cerebral apoplexy — 7 dy.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M E B Owens M. D. or other

Address 133 Va Date signed 11/18/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 8 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10616

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: 518 Louisiana Ave.

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 518 Louisiana Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mrs Ethel J. Copeland

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6 (b) Name of husband or wife: Late John

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Dec - 19 - 1872

8. AGE: Years	Months	Days	If less than one day
66	11	3	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER — 12. Name: George Darr

13. Birthplace: Va

MOTHER — 14. Maiden name: Marcar A. Adams

15. Birthplace: Va

18. Informant: Mrs Raymond Griffith (Daughter)

Address: Cumberland Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof Nov 25 - 39 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Frederick, Maryland

18. Funeral director: W. P. Lamb & Son

Address: Cumberland, Md.

19. Nov 24, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 22 - 1939, at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/15/39 19 to 11/22/39 19, and that I last saw h alive on 11/21/39 19

Immediate cause of death	DURATION
Hypertension	
Chronic Myocarditis	
Due to Arteriosclerosis	
Terminal	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Richard L. Williams, M.D. M. D. or other

Address 34 Va. Ave. Date signed 11/25/39

Cumberland, Md.

RECEIVED
DEC 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(121) to 10617

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 5 days

Stay in this community (yrs., or mos., or days): 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hancock Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Jacob Mark Covalt

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Sylvia Covalt (wife)

6(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): May 6, 1915

8. AGE: Years	Months	Days	If less than one day
24	5	3	hrs. min.

9. Birthplace: Merdmore, Fulton Co. Pa. (Town, county, and state)

10. Usual occupation: Chiropractor

11. Industry or business

FATHER — 12. Name: Elmer Covalt

FATHER — 13. Birthplace: Nerdmore, Pa.

MOTHER — 14. Maiden name: Nellie Bottenfield

MOTHER — 15. Birthplace: Fulton County, Penn.

16. Informant: Lynn Covalt

Address: Warren, Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/6/39 (month) (day) (year)

Cemetery or crematory: Antioch, Cem.

Location: Near Hancock, Md.

18. Funeral director: Snyder-Rowland

Address: Hancock, Maryland

19. Nov. 6 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3 1939, at 322P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 29 1939, to November 3 1939, and that I last saw him alive on November 3 1939.

	DURATION
Immediate cause of death: General peritonitis	6 days
Acute appendicitis (perforated)	6 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings: Acute perforated appendicitis

Of operations: with peritonitis

Of autopsy

PHYSICIAN — Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: James V. Johnson M. D. or other

Address: Cumberland, Md. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T)

Sig. B.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10618

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
MEMORIAL HOSPITAL

Stay in hospital or Insf. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town Cumb. Route #4 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Baltimore Rd
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
BABY GIRL DAVIS (PREMATURE)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 15, 1939

8. AGE:

Years	Months	Days	If less than one day
			2 hrs. min.

9. Birthplace CUMBERLAND, MD.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden name GOLDIE DAVIS
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Cremation Date thereof Nov. 15, 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Memorial Hospital "

Location "

18. Funeral director "
Address

19. Nov. 15 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 15, 1939 at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1939 to Nov 15 1939, and that I last saw her alive on Nov 15 1939.

	DURATION
Immediate cause of death Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wright Reynolds M.D.
M. D. or other
Address Cely Date signed 11/16/39

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DR. REYNOLDS

RECEIVED
DEC 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

10619

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 421 Columbia St.,

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 25 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 421 Columbia St.,
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mrs Bertha M. Diebold

3. (b) Social Security Number:

4. Sex: F.

5. Color or race: W.

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ralph Diebold

B(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): May 31 - 1889

8. AGE: Years: 50 Months: 5 Days: 25 If less than one day: hrs. min.

9. Birthplace: West Va
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Duncan Shields
13. Birthplace: West, Va

MOTHER
14. Maiden name: Elizabeth —
15. Birthplace: West Va

16. Informant: Mrs Pauline Martz - (Daughter)
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 29 - 39 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland Md

18. Funeral director: V. L. Lemparsen

Address: Cumberland, Md.

19. Nov. 28, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-26-39 19 , at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-1-39 19 , to 11-26-39 19 , and that I last saw her alive on 11-25-39 19

Immediate cause of death: Mitral insufficiency — DURATION: ?

Due to: —

Due to: —

Other conditions: Pulmonary edema — 4 days

(Include pregnancy within 3 months of death)

Major findings:

Df operations:

Df autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Cumberland Md Date signed: 11-27-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1939
BUREAU V. S.

10620

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-a) Wolverton

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:
County Allegany
City or town Westernport
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Westernport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 252 Main Extended
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Martin Francis Foley
3. (b) Social Security Number None

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Katherine Joyce Foley
6(c) If alive, give age 74 years
7. Birth date of deceased (mo., day, yr.) April 16 1865
8. AGE: Years 74 Months 7 Days — If less than one day ___ hrs. ___ min.
9. Birthplace Westernport, Md. (Town, county, and state)
10. Usual occupation Laborer - Coal Mine
11. Industry or business
FATHER 12. Name John Foley
13. Birthplace Don't know
MOTHER 14. Maiden name Margaret Maloney
15. Birthplace Don't know
16. Informant Mrs. Katherine Foley
Address Westernport, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 20, 1939 (month) (day) (year)
Cemetery or crematory
Location Terra Alta, W. Va.
18. Funeral director W. H. Fredlock
Address Piedmont W. Va.
19. Nov 17 1939 (Date rec'd by registrar) A. Gazenbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1939, at 4 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16 1939, to Nov 16 1939, and that I last saw him alive on Nov 16 1939.
Immediate cause of death Cerebral Hemorrhage — DURATION 6 hrs
Due to
Due to
Other conditions Arthur Sablensis
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M.D. M. D. or other
Address [illegible] Date signed 11/17/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 4 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

10621

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 412 Cedar St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Stillborn Fosbrink

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) ~~Single, married, widowed, or divorced~~
male	white	Stillborn

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 24, 1939

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace Cumberland, Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Robert Fosbrink

13. Birthplace md.

MOTHER 14. Maiden name Oleta Hill

15. Birthplace md

16. Informant Robert Fosbrink

Address 412 Cedar St

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 25, 1939 (month) (day) (year)

Cemetery or ~~crematory~~ Rose Hill Cemetery

Location Oldtown, Md.

18. Funeral director Louis Stein & Son

Address Cumberland

19. Nov. 25, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1939 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 24 1939 to Nov. 24 1939

and that I last saw him alive on Nov. 24 1939

Immediate cause of death	DURATION
Prematurity	
Due to Complications through Stillborn	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. E. Bowers M. D. or other

Address 133 Va Ave Date signed 11-26-39

RECEIVED
DEC 8 1939
Bureau of V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10622

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 224 Wallace

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 70 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 224 Wallace St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Atsey M. Francis

3. (b) Social Security Number

4. Sex Female

5. Color or race Colored

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Edward Francis

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 70 Months Days If less than one day hrs. min.

9. Birthplace Cumberland Md.

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name James Campbell

13. Birthplace Md.

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Carl Francis

Address Cumberland

17. Burial Date thereof Nov 25 39

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland. Md.

18. Funeral director Louis Stein Inc.

Address 117 Frederick St Cumbd Md

19 Nov. 25, 1939 J. P. Franklin, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1939, at 6:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 23 1939, to Nov 22 1939, and that I last saw her alive on Nov. 22 1939.

Immediate cause of death Edema of Lungs — DURATION 2 day

Due to Cerebral Hemorrhage — 4 weeks

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C. Holloman M.D.

M. D. or other

Address 145 Hanover St Date signed Nov. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

10623

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (820)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Route 3 - Valley Rd - Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 19 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany.

City or town Route 3 - Valley Rd - Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Michael Fresh.

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Margaret Hetrick

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 12 1862

8. AGE: Years 77 Months 7 Days 19 If less than one day ____ hrs. ____ min.

9. Birthplace accident garret Co, Md.
(Town, county, and state)

10. Usual occupation Carpenter.

11. Industry or business Public Works.

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden name Unknown
15. Birthplace Germany.

16. Informant Kermit Van Pelt.
Address Route 3, Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 3, 1939. (month) (day) (year)

Cemetery or crematory Odd Fellows Cemetery.

Location Berlin, Pa.

18. Funeral director Jacob Hafer.
Address Cumberland Md.

19. Nov. 2, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1939, at 6 35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 8 1939, to Nov. 1 1939, and that I last saw him alive on Oct. 31 1939.

Immediate cause of death: Cerebral Hemorrhage — DURATION: 4 weeks

Due to: Cerebral Arteriosclerosis — ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur T. Jones M.D. M. D. or other

Address 40 N. Liberty St. Date signed 11-1-39

Dr Arthur Jones.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1930
BUREAU V. S.

Outside of City Limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-a)

10624

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: North Branch, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: At home of Mrs. Jos. Pollock

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 10 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: North Branch Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Home of Mrs. Jos. Pollock
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary Etta Furlow

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William L. Furlow

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 22, 1861

8. AGE: Years 78 | Months 1 | Days 16 | If less than one day ____ hrs. ____ min.

9. Birthplace: Mt. Herman, Maryland, Allegany
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER
12. Name: Richard L. Zimmerly
13. Birthplace: Maryland

MOTHER
14. Maiden name: Jemima Dennison
15. Birthplace: Maryland

16. Informant: Mrs. Jos. Pollock
Address: North Branch, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 9, 1939 (month) (day) (year)

Cemetery or crematory: Davis Memorial Cemetery

Location: Uhl Highway near North Branch, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Nov 9, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr. M. E. B. Owens

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 7 1939, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 2 1939 to Nov. 7 1939, and that I last saw her alive on Nov. 7 1939.

Immediate cause of death: Arteriosclerosis — DURATION: 3 yr

Due to: Cerebral Apoplexy — 1 day

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: [illegible] Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): [illegible]

Means of injury: Injured at work?

23. SIGNATURE: M E B Owens
M. D. or other

Address: 133 Va Date signed: Nov 8 39

RECEIVED
DEC 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

CERTIFICATE OF DEATH

10625

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Rural near Frostburg, Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Borden Mines

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 78 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Rural Near Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Borden Mines

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Barbara Bennett Gordon

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

B (b) Name of husband or wife Wm Thos. Gordon

B(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 17 - 1853

8. AGE:

Years	Months	Days	If less than one day
86	6	5	____ hrs. ____ min.

9. Birthplace Cheneyaville, Bedford, Pa.
(Town, county, and state)

10. Usual occupation House work

11. Industry or business At Home

FATHER
12. Name Abram Bennett
13. Birthplace Black Valley Township, Pa

MOTHER
14. Maiden name Amelia Stevens
15. Birthplace Cheneyaville, Pa.

16. Informant Abram Gordon.
Address Mt. Savage. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 25, 1939 (month) (day) (year)

Cemetery or crematory Percy Cemetery

Location Frostburg, Md

18. Funeral director Jacob Hafer.

Address Frostburg Md.

19. Nov. 25 1939 mca (Date rec'd by registrar) A. R. Walker Registrar

Dr Cobey.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1939, at 9A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 27 1939 to Nov 23 1939

and that I last saw h alive on Nov. 8 1939

Immediate cause of death	DURATION
Coma	
Due to Chronic Nephritis	
Due to Carcinosarcoma	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Ot operations

Ot autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J A Cobey M. D., or other

Address Frostburg Md Date signed 11-24-39

RECEIVED
DEC 2 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

10626

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 608 N. Mechanic St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 608 N. Mechanic
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elizabeth Grotte

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John Grotte
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 5, 1876

8. AGE:

Years	Months	Days	If less than one day
63	3	10	hrs. min.

9. Birthplace Switzerland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At Home
FATHER 12. Name Andrew Hasselberger
13. Birthplace Germany
MOTHER 14. Maiden name Agatha Boeder
15. Birthplace Germany
16. Informant Frank Hasselberger
Address Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 17, 1939 (month) (day) (year)
Cemetery or crematory St. Peters and Pauls
Location Cumberland, Md.
18. Funeral director V. L. Lemperenus
Address Cumberland, Md.
19. Nov. 17, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1939 at 6:55 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 3 1939 to Nov. 15 1939 and that I last saw h[illegible] alive on Nov. 5 1939

Immediate cause of death	DURATION
Arteriosclerosis	2
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations None.
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other
Address Cumberland Md. Date signed 11-16-39

RECEIVED
DEC 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82a)

CERTIFICATE OF DEATH

10627

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 19 Virginia Avenue
Stay in hospital or Inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 40 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 19 Virginia Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Francis Albert Hartell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Anna E. Snyder
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 28, 1872

8. AGE: Years	Months	Days	If less than one day
67	10	1	hrs. min.

9. Birthplace: Piedmont, West Virginia (Town, county, and state)
10. Usual occupation: Machinist, Retired
11. Industry or business: B. & O. Railroad

FATHER
12. Name: Francis A. Hartell
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mr. Frank W. Hartell
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 2, 1939 (month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Dec. 2, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr. M. E. Owens

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1939, at 12 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1937, to Nov 29 1939, and that I last saw h— alive on Nov. 29 1939.

	DURATION
Immediate cause of death	
Cerebral Apoplexy	about 3 yrs.
Due to arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Nil Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Nil
Means of injury: Injured at work?

23. SIGNATURE: M. E. Owens M. D. or other
Address: 133 Va Ave Date signed: Dec 4 39

RECEIVED
DEC 9 1939
U. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (186-a)

Reg. Dist. No. 4

CERTIFICATE OF DEATH

10628

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 721 Columbia Avenue
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 76 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Maryland (b) County Allegany
(c) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 721 Columbia Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Christina C. Henkel

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Arnold Carl Henkel

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1863

8. AGE: Years 76 Months 3 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At home

FATHER
12. Name August Quantz
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Schaidt
15. Birthplace Maryland

16 (a) Informant Mrs. Carl Lapp
(b) Address Cumberland, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15, 1939 (month) (day) (year)
(c) Cemetery or crematory Greenmont Cemetery
Location Cumberland, Md.

18 (a) Funeral director Louis Stein, Inc.
(b) Address Cumberland, Md.

19 (a) Nov. 14, 1939 (Date rec'd by registrar) (b) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. Date of death Nov 12 1939, at 2 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1939, to Nov 12 1939, and that I last saw him or alive on Nov 11 1939.

Immediate cause of death Edema of the lungs

Duration 4 days

Due to Fracture surgical neck of femur since Oct 15/39 also Due to accidental fall

Due to Hemiplegia with unilateral paralysis affecting heart. Apoplexy, three years ago.

Other conditions Cardiac hypertrophy
(Include pregnancy within 3 months of death)

Major findings Of operations Was walking in the house, with a cane; accidentally fell, fracturing

Of autopsy her femur.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident.
(b) Date of occurrence October 15th, 1939.
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? in her home. While at work? _____
(Specify type of place)
(e) Means of injury Accidental fall.

23. Signature T. N. Deming M. D.
M. D. or other

Address 67 N Center St Date signed 11/13/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10629

CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Westernport

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 215 Walnut

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 5 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Westernport Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 215 Walnut

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Edward Henry

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of husband or wife Emma A. Henry.

6(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Mar 15, 1869

8. AGE:

Years	Months	Days	If less than one day
70	7	20	hrs. min.

9. Birthplace Piedmont - Mineral, W. Va. (Town, county, and state)

10. Usual occupation Track - foreman

11. Industry or business Railroad.

FATHER 12. Name Levi Henry.

13. Birthplace W. Va

MOTHER 14. Maiden name Mary Wisenberg

15. Birthplace W. Va.

16. Informant Emma A. Henry

Address Westernport, Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Nov 23, 1939 (month) (day) (year)

Cemetery or crematory Philos

Location Westernport Md

18. Funeral director D. E. Boal

Address Westernport, Md.

19. Nov. 23 1939 (Date rec'd by registrar) J. Raymond Baker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1939, at 7:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1939 19 , to Nov 20 19 39

and that I last saw him alive on Nov. 20 19 39

Immediate cause of death Broncho-Pneumonia DURATION 2 days

Due to Hypostatic type Cystitis 4 yrs

Due to Enlarged Prostate

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P E Berry M.D. M. D. or other

Address Piedmont W Va Date signed 11/20/39

RECEIVED
DEC 4 1900
BUREAU

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

CERTIFICATE OF DEATH

10630

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 13 Pennsylvania Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John Edward Hoadley

3. (b) Social Security Number: 705-07-6566

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Jennie C. Faherty
6(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Sept. 30, 1885

8. AGE: Years	Months	Days	If less than one day
54	1	4	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: Engineer
11. Industry or business: B. & O. Railroad
FATHER 12. Name: David Hoadley
13. Birthplace: Terra Alta, W. Va.
MOTHER 14. Maiden name: Emma Saylor
15. Birthplace: West Virginia
16. Informant: James E. Hoadley
Address: Cumberland, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 6, 1939 (month) (day) (year)
Cemetery or crematory: St. Patrick Cemetery
Location: Cumberland, Maryland
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland
19. Nov. 4, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3/39, 19, at 8 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/20/39 19 to 11/3/39 19, and that I last saw him alive on 11/2/39 19.

Immediate cause of death: Hypertension Chr Myocarditis — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:
Ct operations:
Dt autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Richard J. Williams M.D.
M. D. or other
Address: 34 Va. Ave. Cumberland, Md. Date signed 11/3/39

NOV 9 1939
BUREAU V.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73)

CERTIFICATE OF DEATH

10631

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany County
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days): 21 days
Stay in this community (yrs., or mos., or days): 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 139 N. Center St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Margaret Knepp

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: John Knepp
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 16, 1890

8. AGE: Years	Months	Days	If less than one day
49	7	23	hrs. min.

9. Birthplace: Pennsylvania
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home

FATHER
12. Name: Louis Knepp
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Agnes Suder
15. Birthplace: Pennsylvania

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 12, 1939 (month) (day) (year)
Cemetery or crematory: White Oak Cemetery
Location: Somerset County, Penna.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Nov. 11, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. W.F. WILLIAMS

MEDICAL CERTIFICATION 10:22

20. DATE OF DEATH: November 8, 1939, at A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-18-1939, to 11-8-1939 and that I last saw her alive on 11-8-1939

Immediate cause of death	DURATION
Uremia	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: none
Of autopsy: Confirmed diagnosis

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: City Date signed: 11-9-39

RECEIVED
DEC 8 1930
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

10632

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing, Md. (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: State Street

Stay in hospital or Inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 12 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: State Street (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Edward Lancaster

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6(b) Name of husband or wife: Ada Schaidt Lancaster

6(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): October 19, 1876

8. AGE:

Years	Months	Days	If less than one day
63	—	23	hrs. min.

9. Birthplace: Garrett County, Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER — 12. Name: Andrew Lancaster

FATHER — 13. Birthplace: Garrett County, Maryland

MOTHER — 14. Maiden name: Charlotte Dawson

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Ada Lancaster

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof November 15 1939 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: M. Eichhorn,

Address: Lonaconing, Md.

19. Nov. 15 1939 (Date rec'd by registrar) H. E. Boyd Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 13 1939, at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1937, to Nov. 10 1939, and that I last saw him alive on Nov. 10 1937

	DURATION
Immediate cause of death: Coronary Thrombosis	1 year
Due to:	
Due to:	
Other conditions: Hypertension	2 years

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Joseph Friedman M. D. or other

Address: Westernport Date signed 11-14-39

RECEIVED
DEC 7 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B2a)

CERTIFICATE OF DEATH

10633

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 I

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Miners Hospital
Stay in hospital or inst. (yrs., or mos., or days): 1 day
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 161 W. Main St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Letitia Friend Layman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Albert Layman
6(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Feb. 27, 1893

8. AGE:

Years	Months	Days	If less than one day
46	9	3	hrs. min.

9. Birthplace: Friendsville, Md
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:
FATHER 12. Name: Andy Friend
FATHER 13. Birthplace: Friendsville, Md.
MOTHER 14. Maiden name: Mary Lisle
MOTHER 15. Birthplace: Maryland
16. Informant: Albert Layman,
Address: 161 W. Main St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 3, 1939 (month) (day) (year)
Cemetery or crematory: Mt. Zion Cemetery
Location: Garrett Co.
18. Funeral director: J. J. Durst
Address: Frostburg Md.
19. 12-3 1939 mo. A. R. Walker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month) Nov. 30 1939 at 1.40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 29 1939 to Nov. 30 1939
and that I last saw h-- alive on Nov. 30 1939

Immediate cause of death	Cerebral hemorrhage	DURATION
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. C. Osborn M. D. or other
Address: Frostburg Md. Date signed 12-2-39

RECEIVED
JAN 9 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-E

CERTIFICATE OF DEATH

10634

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany County
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days): 15 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W. Va. County: Mineral
City or town: Piedmont Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 18 E. Hampshire St.,
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: James LaRue

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Theresa Leavy
6(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): June 8, 1865

8. AGE: Years	Months	Days	If less than one day
74	5	14	hrs. min.

9. Birthplace: West Virginia Harpers Ferry
(Town, county, and state)

10. Usual occupation: Unable to work

11. Industry or business

FATHER
12. Name: Moses LaRue
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Mary ? LaRue
15. Birthplace: West Virginia

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 25-1939 (month) (day) (year)
Cemetery or crematory: Rhobs Cemetery
Location: Westernport, Md.

18. Funeral director: David S. Boal
Address: Westernport, Md.

Nov. 22, 1939 (Date rec'd by registrar) J. P. Franklin M. D. Registrar

DR. TOLSON

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22, 1939, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-1- 1939, to 11-22- 1939, and that I last saw him alive on 11-21- 1939.

	DURATION
Immediate cause of death: Myocardial degeneration	
Arteriosclerosis	
Due to	
Due to	
Other conditions: Benign hypertrophy of Prostate	about 5 yrs.

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: injured at work?

23. SIGNATURE: Howard L. Tolson M.D.
M. D. or other
Address: Cumberland, Md. Date signed 11-22-39

RECEIVED
DEC 8 1939
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(46-B)

10635

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany

City or town Westernport
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: 147 Wood Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 36 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Westernport, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 147 Wood St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Norah Lou Lichliter

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Peter Cooley Lichliter

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept 19, 1876

8. AGE: Years 62 | Months 2 | Days 3 | If less than one day ____ hrs. ____ min.

9. Birthplace Fort Ashby, Mineral, W. Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER
12. Name John J. Greenwade
13. Birthplace Brady, Md.

MOTHER
14. Maiden name Sarah E. Wheeler
15. Birthplace Frankford, W. Va.

16. Informant Mrs. Raymond Wolford

Address 147 Wood St. Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 26, 1939 (month) (day) (year)

Cemetery or crematory Philos

Location Westernport

16. Funeral director D. S. Boal

Address Barton, Md.

19. Nov. 23 1939 (Date rec'd by registrar) A. Gaynbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1939, at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 12 1939, to Nov 22 1939, and that I last saw her alive on Nov 22 1939.

Immediate cause of death Intestinal obstruction

Primary carcinoma of stomach. CWGA

Due to Carcinomatosis

Due to Duration: two to three years.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H. Wolverton, Jr., M.D. M. D. or other

Address Piedmont W. Va. Date signed 11/22/39

RECEIVED
DEC 4 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72-a)

CERTIFICATE OF DEATH

10636

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 226 Emily Street
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 226 Emily Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Susan McCulley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: John McCulley
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 22, 1849

8. AGE: Years	Months	Days	If less than one day
90	2	22	hrs. min.

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home
FATHER 12. Name: John Moreland
FATHER 13. Birthplace: West Virginia
MOTHER 14. Maiden name: Polly McBride
MOTHER 15. Birthplace: West Virginia
16. Informant: Charles McCulley
Address: Cumberland, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 15, 1939 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Md.
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.
19. Nov. 14, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

Dr. M.E.B. Owens

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 13 1939, at 10:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1937 to Nov 13 1939 and that I last saw h[illegible] alive on Nov. 13 1939.

	DURATION
Immediate cause of death: Chronic Valvular Heart disease	short
Due to: Arteriosclerosis	3 yr
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: No Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): No
Means of injury: Injured at work?

23. SIGNATURE: M.E.B. Owens M. D. or other
Address: 33 Va Ave Date signed Nov 14 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

10637

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 234 Cecelia
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 234 Cecelia
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Willahelmia McKay

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Wm McKay
6(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1871

8. AGE:

Years	Months	Days	If less than one day
67	11	13	hrs. min.

9. Birthplace Catskeville Md
(Town, county, and state)
10. Usual occupation Housekeeper
11. Industry or business At home
FATHER 12. Name Karl Boettcher
13. Birthplace Germany
MOTHER 14. Maiden name Charlotta Lawrence
15. Birthplace Hanover Germany
16. Informant Kathryn Moyer
Address Aberdeen Md
17. Burial Date thereof Nov. 4, 1939
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Lukes Lutheran
Location Cumberland
18. Funeral director Jacob Lefer
Address Cumberland, Md.
19. Nov. 4 1939 J. P. Franklin, M.D.
(Date rec'd by registrar) Regiatrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1939, at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1939, to Nov 1 1939, and that I last saw h alive on Nov. 1 1939.

Immediate cause of death	DURATION
Cerebral Arterio Sclerosis	6 Months
Due to ?	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE C. L. Lanich M. D. or other
Address Cumberland Md Date signed 11/2 39

Dr. Lanich

RECEIVED
DEC 8 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-c)

CERTIFICATE OF DEATH

10638

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

I. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 223 Carroll Street

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 60 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.:

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 223 Carroll Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Enoch A. McKenzie

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Margaret Rohman

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 22, 1858

8. AGE: Years	Months	Days	If less than one day
81	5	5	hrs. min.

9. Birthplace: Cresaptown, Maryland (Town, county, and state)

10. Usual occupation: Brewery Worker

11. Industry or business: Retired

FATHER — 12. Name: George McKenzie

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Susan ~~Unknown~~ McKenzie

MOTHER — 15. Birthplace: Unknown

16. Informant: Mr. Clarence McKenzie

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 29, 1939 (month) (day) (year)

Cemetery or crematory: St. Peter & Paul Cemetery

Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Nov 28, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 27 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1939, to Nov 27 1939 and that I last saw him alive on Nov 26 1939

Immediate cause of death	DURATION
Chronic myocarditis	2 yrs.
Due to	
Due to	
Other conditions: Arteriosclerosis	3 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy: none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. A. Trwaski M.D. M. D. or other

Address: Cumberland md. Date signed: Nov 27-39

RECEIVED
DEC 6 1939
BUREAU V. S.

Outside of City Limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (165)

10639

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Bowman Addition

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 30 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Bowman Addition (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: William E. McLucas

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charlotte Day

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years: 71 Months: Days: If less than one day: hrs. min.

9. Birthplace: Fulton County, Penna. (Town, county, and state)

10. Usual occupation: Sewer service

11. Industry or business: City of Cumberland

FATHER
12. Name: William McLucas
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary ???
15. Birthplace: Unknown

18. Informant: Mr. Harry McLucas
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 17, 1939 (month) (day) (year)

Cemetery or crematory: Everett Cemetery

Location: Everett, Pennsylvania

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Maryland

19. Nov. 17, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15th., about 1939, at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death: Strangulation by hanging.

Due to:

Due to:

Other conditions: Ill health, despondency (Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: no autopsy

DURATION: 2 months

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: suicide Date of: 11/15/1939

Where did injury occur? Cumberland, (City or town) R.F.D. (County) Allegany, Md. (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: hanging Injured at work? no

23. SIGNATURE: [signature] M.D. (M. D. or other)

Address: Cumberland, Maryland Date signed: 11/16/39

Deputy Medical Examiner - Allegany Co.

RECEIVED
DEC 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-3)

CERTIFICATE OF DEATH

10640

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 125 North Centre Street
Stay in hospital or inst. (yrs., or mos., or days): 83 years
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 125 North Centre Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Katherine Nickel

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 13, 1855

8. AGE: Years: 83 | Months: 10 | Days: 21 | If less than one day: hrs. min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation: ~~Retire~~ Housekeeper

11. Industry or business:

FATHER
12. Name: Adam Nickel
13. Birthplace: Germany

MOTHER
14. Maiden name: Barbara Snyder
15. Birthplace: Germany

16. Informant: Mr. Henry Nickel
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 5, 1939 (month) (day) (year)
Cemetery or crematory: St. Luke Cemetery
Location: Cumberland, Maryland

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland

19. Nov. 4 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 3 1939, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 - 1939 to Nov 3 1939 and that I last saw her alive on Nov. 3 1939

Immediate cause of death		CURATION
	Angina Pectoris	1 yr.
Due to	arterio-Sclerosis	5 yrs.
Due to		
Other conditions	Myocarditis Chronic	5 yrs.

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Walter R. Frantz M.D.
M. D. or other
Address: Cumberland Md. Date signed: 11/3/39

RECEIVED
DEC 6 1939
BUREAU V. S.
RECEIVED
DEC 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10641 9

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: allegany
City or town: Vale Summit
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: allegany
City or town: Vale Summit Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(if rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Louis C. Parker
3. (b) Social Security Number

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced: single
8 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Oct. 12 - 1866
8. AGE: Years 73 Months 1 Days 11 If less than one day hrs. min.
9. Birthplace: Mt Savage - alleg - Md.
(Town, county, and state)
10. Usual occupation: store keeper
11. Industry or business
FATHER 12. Name: Josiah Parker
13. Birthplace: Md.
MOTHER 14. Maiden name: Eliza Baker
15. Birthplace: England
16. Informant: Mrs Walter Parker
Address: Vale Summit, Md.
17. burial (Burial, cremation, or removal. Which?) Date thereof: Nov 26 1939 (month) (day) (year)
Cemetery or ~~crematory~~: allegany
Location: Frostburg
18. Funeral director: J. J. Durst
Address: Frostburg
19. 11-25th 1939 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 23 1939, at 11:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1939, to Nov 23 1939, and that I last saw him alive on Nov 10 1939.
Immediate cause of death: Angina Pectoris — DURATION: ?
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. O. McLane Jr. M.D.
M. D. or other
Address: Frostburg Md. Date signed: Nov 24 '39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 2 1930
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93-C)

Reg. Dist. No. 1

CERTIFICATE OF DEATH

10642

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Oldtown
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Oldtown
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Micheal John Piper

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ella Piper

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/25/1874

8. AGE: Years 65 Months 7 Days 28 If less than one day hr. min.

9. Birthplace Oldtown
(Town, county, and state)

10. Usual occupation W P A

11. Industry or business Road Work

FATHER
12. Name John Piper
13. Birthplace Oldtown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Guy Piper
(b) Address Oldtown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/39 (month) (day) (year)
(c) Cemetery or crematory Oldtown Cem
Location Oldtown Md

18 (a) Funeral director Wm H. Kight
(b) Address Cumberland Md

19 (a) 11/24/39 (Date rec'd by registrar) (b) Carrie A. Shimholt Registrar

MEDICAL CERTIFICATION

20. Date of death November 23rd., 1939, at about 4.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw him alive on 19.

Immediate cause of death Chronic Myocarditis — Duration 2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Prince H. Cowan, M.D. M. D. or other
Address Cumberland, Md. Date signed 11/24/1939

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 7 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (8)

Reg. Dist. No. 9

10643

CERTIFICATE OF DEATH

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution Miners Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in this community (yrs., mos., or days) —

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town ~~Frost~~ Eckhart (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Still born Lephaum

3 (b) If veteran, name war ✓

3 (c) Social Security No. ✓

4. Sex ✓

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 5-1939

8. AGE: Years ✓ Months ✓ Days ✓ If less than one day ✓ hr. ✓ min.

9. Birthplace Frostburg, Md (Town, county, and state)

10. Usual occupation

11. Industry or business —

FATHER

12. Name James E. Lephaum

13. Birthplace Eckhart Md.

MOTHER

14. Maiden Name Millicent E. Lephaum

15. Birthplace National Md.

16 (a) Informant Millicent E. Lephaum

(b) Address Eckhart Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 11 5 39

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) Nov. 6th 39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death Nov. 5 1939, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw him alive on 19 .

Immediate cause of death Not at all Still born

Due to ~~Premature birth~~

Due to Abutment at 2nd mine.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations Partial of placenta removal

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged ststistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. C. Cobey M.D. M. D. or other

Address Frostburg Md Date signed Nov. 5-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 2 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

10644

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 7 Days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland R.D.#2. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Near Twiggtown
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: George Bruce Robinette

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 22, 1856.

8. AGE: Years	Months	Days	If less than one day
83	2	11	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business:

FATHER
12. Name: George Robinette
13. Birthplace: Maryland

MOTHER
14. Maiden name: Emeline Perry
15. Birthplace: Maryland

16. Informant: Mrs. Geo. B. McLaughlin
Address: 731 Cleveland Ave. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 5, 1939 (month) (day) (year)

Cemetery or crematory: Green Meadows Cem.

Location: Murleys Branch

18. Funeral director: J. C. Wolford
Address: Cumberland, Md.

19. Nov. 4 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 3, 1939, at 625 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 20 1939, to Nov 3 1939, and that I last saw ~~him~~ alive on Nov. 2 1939.

Immediate cause of death	DURATION
Uremic Coma	4 Days
Due to Chronic nephritis	1 year
Due to Chronic myocarditis	1 year

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thos. A. Frank M. D. or other
Address: Cumberland Date signed: Nov. 3-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 5 1939
BUREAU, V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10645

(93-c)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 403 Sheridan Place

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 403 Sheridan Place

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Minerva Jane Robinette

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Henry C. Robinette

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1846

8. AGE:

Years	Months	Days	If less than one day
92	11	1	____ hrs. ____ min.

9. Birthplace Chaneysville, Penna. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At home

FATHER 12. Name George O'Neal

13. Birthplace Pennsylvania

MOTHER 14. Maiden name Mary Northcraft

15. Birthplace Pennsylvania

16. Informant Mr. Sanford Robinette

Address Cresaptown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 15, 1939 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Maryland

18. Funeral director Louis Stein, Inc.

Address Cumberland, Maryland

19. Nov. 14, 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1939, at 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 10 1939, to Nov 12 1939, and that I last saw her alive on Nov 12 1939.

Immediate cause of death Obstruction of Bowels: Primary cause: Unknown. Not due to cancer. CWSR.

Due to Infirmities of Age

Due to Chronic Myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 2 days; 2 yrs

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. [illegible] M. D. or other

Address Cumberland Md Date signed Nov 13-39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 8 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

46-C

10646

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany County
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days): 28 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Virginia County: Preston
City or town: Terra Alta Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: William H. Rodeheaver

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Oct. 18, 1873
8. AGE: Years 66 Months 0 Days 16 If less than one day ____ hrs. ____ min.
9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: General laborer
11. Industry or business
FATHER
12. Name: Charles Rodeheaver
13. Birthplace: West Virginia
MOTHER
14. Maiden name: Elizabeth Albright
15. Birthplace: West Virginia
16. Informant: Memorial Hospital
Address: Cumberland, Md.
17. Removal & Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 4, 1939 (month) (day) (year)
Cemetery or crematory: Terra Alta Cemetery
Location: Terra Alta W. Va.
18. Funeral director: Prentice R. Watson
Address: Terra Alta, W. Va.
19. Nov. 4, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4, 1939, at 11A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 5 1939, to Nov 2 1939 and that I last saw him alive on Nov 4 1939
Immediate cause of death: Carcinoma of small intestines
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations: Small intestine obstructed with malignant growth.
Of autopsy
DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: S. E. Enfield M. D. or other
Address: Cumberland Date signed 11/4/39

DR. ENFIELD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1939
BUREAU V. S.

Dr Emfield
Stand Hubi

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10647

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (Extended) Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution: 14 Decatur St.,
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, writs RURAL NEAR and give town)
Street No. 14 Decatur
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Mrs Elizabeth Schaidt

3. (b) Social Security Number: —

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F.	W.	Widowed

6 (b) Name of husband ~~or wife~~: Late John

6 (c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 15 1854

8. AGE:

Years	Months	Days	If less than one day
85	6	7	—hrs. —min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: George Knatz
13. Birthplace: Germany

MOTHER
14. Maiden name: Elizabeth Wilhelm
15. Birthplace: Germany

16. Informant: John Schaidt
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 25/39 (month) (day) (year)

Cemetery or crematory: Rose Hill
Location: Cumberland Md

18. Funeral director: V. L. Lamberson
Address: Cumberland Md.

19. Nov. 24 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-22-39 19 at 2:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-1-39 19 to 11-22-39 19, and that I last saw her alive on 11-21-39 19

Immediate cause of death	DURATION
Bronchial Pneumonia	
Due to 2.	
Due to 1.	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: O. S. Zimmerman M. D. or other
Address — Date signed 11-24-39

RECEIVED
DEC 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (131) Reg. Dist. No. 4

CERTIFICATE OF DEATH

10648

1. PLACE OF DEATH

(a) County Allegany

(b) City or town Cumberland (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos. 7 days

(e) Length of stay in this community (yrs., mos., or days) 26 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town LaVale (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Minnie Margaret Langer Schulz

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Henry J. Schulz

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23 1854

8. AGE: Years 85 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace Cumberland, Md. (town, county, and state)

10. Usual occupation Seamstress

11. Industry or business At Home

FATHER 12. Name Chas. A. Langer

FATHER 13. Birthplace Holland

MOTHER 14. Maiden Name Christina Stauch

MOTHER 15. Birthplace Germany

16 (a) Informant Chas. Langer

(b) Address 405 N. Centre St., City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20, 1939 (month) (day) (year)

(c) Cemetery or crematory St. Lukes Cem

Location Cumberland, Md.

18 (a) Funeral director Jacob Hafer

(b) Address Cumberland, Md.

19 (a) Nov 17, 1939 (Date rec'd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death Nov 15 1939, at 12 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1939, to Nov 15 1939, and that I last saw him/her alive on Nov 14 1939.

Immediate cause of death	Duration
Cardiac depression due to hypostatic congestion of lungs	4 days
Due to Chronic interstitial nephritis	several yrs
Due to Cardiac hypertrophy	several yrs
Other conditions Arteriosclerosis	several yrs

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. V. Deming M.D. (M. D. or other)

Address 67 N. Centre St Date signed 11-15-39

Cumberland, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 6 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (124C)

CERTIFICATE OF DEATH

10649

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Vale Summit
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or insf. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Vale Summit Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Martha E. Scott
3. (b) Social Security Number: —

4. Sex: F
5. Color or race: W
6. (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Wm C. Scott
6 (c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Jan 26 – 1896
8. AGE: Years 43 Months 9 Days 9 If less than one day ____ hrs. ____ min.
9. Birthplace: Loantown, Alleg. Md. (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business
FATHER
12. Name: J. I. Bluebaugh
13. Birthplace: Loantown, Md.
MOTHER
14. Maiden name: Elizabeth Legue
15. Birthplace: Ireland
16. Informant: Mrs Mary Fathin
Address: Loantown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 19 – 1939 (month) (day) (year)
Cemetery or crematory: Vale Summit
Location: Vale Summit
18. Funeral director: J. J. Durst
Address: Frostburg, Md
19. 11 – 19th 1939 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 17 1939, at 8:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28 1938, to Nov 17 1939, and that I last saw her alive on Nov 16 1939.

Immediate cause of death	DURATION
Chronic Cirrhosis of liver	1 yr
Due to Chronic Myocarditis	4 yr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury ____ Injured at work?

23. SIGNATURE: W. O. McLane Jr. M.D. M. D. or other
Address: Frostburg Md. Date signed: Nov 18 39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 2 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

10650

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH:
County: Allegany
City or town: Barton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Temperance
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 30 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Barton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Sarah Agnes Shaw

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband ~~or wife~~: Harry Lucas Andrews
6(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): May 20. 1896

8. AGE: Years: 43 | Months: 5 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Moscow Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER
12. Name: Joseph Shaw
13. Birthplace: Moscow Md.

MOTHER
14. Maiden name: Sarah Mason
15. Birthplace: Pittsburg Penna.

16. Informant: Harry Lucas Andrews
Address: Barton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 7 1939 (month) (day) (year)
Cemetery or crematory: Rockhill Cemetery
Location: Moscow Md.

18. Funeral director: David L. Beal
Address: Barton md

19. Nov 6 1939 (Date rec'd by registrar) E. A. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 4 1939, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 30 1939, to Nov 4 1939, and that I last saw her alive on Nov 4 1939.

Immediate cause of death	DURATION
Carcinoma of left breast with secondary	6 mo
Due to Carcinoma of liver.	3 wks
Due to	
Other conditions Jaundice	2 wks

(Include pregnancy within 3 months of death)

Major findings:
Of operations: —
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thomas Reese M D
M. D. or other
Address: Westernport Md. Date signed: Nov 4, 1939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 5 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (45-D) Reg. Dist. No. 2

CERTIFICATE OF DEATH

10651

VS. A15 (Y)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) County Allegheny
(b) City or town Flintstone
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 23 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegheny
(c) City or town Flintstone Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Martin Vanburan Smith

3 (b) If veteran, name war
3 (c) Social Security No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15 1848

8. AGE: Years 91 | Months | Days 21 | If less than one day ____hr. ____min.

9. Birthplace Pa
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business

FATHER 12. Name Harry Smith
13. Birthplace Pa

MOTHER 14. Maiden Name Rachel Martin
15. Birthplace Pa

16 (a) Informant Agnes Shoemaker
(b) Address Cumberland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 8 1939 (month) (day) (year)
(c) Cemetery or crematory Fairview
Location Bedford Co. Pa

18 (a) Funeral director Ephraim Smith
(b) Address Martinsburg

19 (a) Nov. 6-39 (Date rec'd by registrar) (b) D Bennett Registrar

MEDICAL CERTIFICATION

20. Date of death Nov. 5 1939, at 5:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1939, to Nov. 5 1939, and that I last saw him alive on July 18 1939.

Immediate cause of death	Duration
Adeno Carcinoma of Superior maxilla	Short time.
Due to	
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. **Signature** Esther F. Jones M. D.
M. D. or other
Address 40 N. Liberty St. Date signed 11-6-39

RECEIVED
DEC 6 1938
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

10652

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hosp.

Stay in hospital or inst. (yrs., or mos., or days) Allegany

Stay in this community (yrs., or mos., or days) Since Oct 9 39

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wash.

City or town Hancock Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Melva Albertus Sanders

3. (b) Social Security Number 705-05-9182

4. Sex: Male

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jenny Sanders

Mellott

6(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1879

8. AGE: Years 60 Months 0 Days 20 If less than one day ___ hrs. ___ min.

9. Birthplace Hancock Md. (Town, county, and state)

10. Usual occupation R R Laborer

11. Industry or business B & O

FATHER 12. Name Arthur Sanders

13. Birthplace Md.

MOTHER 14. Maiden name Elizabeth Holbert

15. Birthplace Md.

16. Informant Harris Sanders

Address Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 11, 1939 (month) (day) (year)

Cemetery or crematory Episcopal Cem.

Location Hancock, Md.

18. Funeral director T P Jenkins

Address Hancock Md.

19. Nov. 9, 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1939, at 4:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 9 1939, to November 9 1939, and that I last saw him alive on November 8 1939.

Immediate cause of death	DURATION
Cerebral Accident (hemorrhage)	3 mo.
~~Due to~~ Chronic Nephritis —	???
~~Due to~~ Cystitis —	3 weeks

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Overhaus M.D. M. D. or other

Address 119 Bedford St. Cumberland, Md. Date signed 11/9/39

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 29 1939
BUREAU V. R.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-a)

CERTIFICATE OF DEATH

10653

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH: Allegany
County
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 410 Oldtown Rd., East
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 30 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 410 Oldtown Rd., East
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Aaron Edward Steely

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ida Taschenberger
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Unknown
8. AGE: Years 57 Months Days If less than one day hrs. min.
9. Birthplace: Millersburg, Penna. (Town, county, and state)
10. Usual occupation: Machinist Helper
11. Industry or business: B. & O. Railroad
FATHER 12. Name: George M. Steely
13. Birthplace: Pennsylvania
MOTHER 14. Maiden name: Audrea Nace
15. Birthplace: Pennsylvania
16. Informant: Marlin L. Steely
Address: Cumberland, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 9, 1939 (month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland, Maryland
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Maryland
19. Nov. 9 1939 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

Dr. M. E. B. Owens

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1939 at 10 P M
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Aug 15 1939 to Nov. 7 1939, and that I last saw h— alive on Nov. 7 1939
Immediate cause of death: Arterio sclerosis — DURATION 4 yr.
Due to: Cerebral Apoplexy — 2 mos.
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE M. D. or other
Address 133 Va. Ave. Date signed 11/8/39

RECEIVED
DEC 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

10654

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address (hospital, or institution): Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days) 1 day
Stay in this community (yrs., or mos., or days) 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Route #2
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Oliver Glover Stevens

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife Single
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 10, 1869

8. AGE:

Years	Months	Days	If less than one day
70	5	19	____ hrs. ____ min.

9. Birthplace Artemas Pa
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Own Farm

FATHER
12. Name Denton Stevens
13. Birthplace Everett Pa.

MOTHER
14. Maiden name Ellen Yates
15. Birthplace Everett, Pa.

16. Informant Roy Miller
Address Cumberland Route #2

17. Burial (Burial, cremation, or removal? Which?) Date thereof Dec. 2, 1939 (month) (day) (year)
Cemetery or crematory Pleasant Grove
Location Cumberland Route #2

18. Funeral director Jacob Hafer
Address Cumberland

19. Dec. 1, 39 (Date rec'd by registrar) J. L. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1939, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 29 1939 to November 29 1939, and that I last saw him alive on November 29 1939.

Immediate cause of death	DURATION
Uremia	???
Due to Chronic Nephritis	???
Due to Hypertensive Cardio-vascular Renal Disease	???
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel Jacobson M.D.
M. D. or Other
Address 119 Bedford St Date signed 12/1/39

RECEIVED
DEC 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

10655

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 206 Beall St., City
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Baby Girl Stimler

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife: None

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 6, 1939

8. AGE: Years | Months | Days | If less than one day: hrs. 22 min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Robert Stimler
13. Birthplace: California

MOTHER
14. Maiden name: Mary Cook
15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 8 1939 (month) (day) (year)
Cemetery or crematory: Allegany County Cemetery
Location: Cumberland, Md.

18. Funeral director: Geo. Stein, Inc.
Address: Cumberland Md.

19. Nov. 7 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. HODGES

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6, 1939 at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 6 1939 to Nov. 6 1939 and that I last saw h-e alive on Nov. 6 1939.

Immediate cause of death	Prematurity	DURATION
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. R. Hodges M. D. or other
Address: Cumberland Md Date signed: 11/6/39

RECEIVED
DEC 6 1939
BUREAU V. S.

Outside of
WITHIN CORPORATE LIMITS.
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

10656

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: ~~ROUTE 4, Baltimore Pike~~ Memorial Hosp.

Stay in hospital or inst. (yrs., or mos., or days) Two days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Route 4, Baltimore Pike
(If rural give LOCATION)

2(o) IF VETERAN, NAME WAR

3. (a) FULL NAME

Mr. Howard Sulser

3. (b) Social Security Number

4. Sex	5. Color or race	6.(o) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Clarabelle Keefer Sulser

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 57 | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace Maryland
(Town, county and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name David Sulser

13. Birthplace W. Va.

MOTHER 14. Maiden name Naomi Beavers

15. Birthplace Maryland

16. Informant Memorial Hospital

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 13, 1939 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director M. Eichhorn

Address Lonaconing, Md.

19. Nov. 11, 1939 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1939, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 9, 1939, to Nov. 11, 1939, and that I last saw him alive on Nov. 11, 1939.

Immediate cause of death	DURATION
Chronic Nephritis	
Chronic Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard J. Williams, M.D. M. D. or other

Address 34 Va. Ave. Date signed 11/14/39

Dr. R. Williams

RECEIVED
DEC 8 1939
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-C) C13

CERTIFICATE OF DEATH

Reg. Dist. No. 6 — 10657

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Reevs Clinic

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: W. Va. County:

City or town: Keyser Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.:

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Infant of Leroy Newman Suter

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 1, 1939

8. AGE: Years | Months | Days | If less than one day: 1 hrs. min.

9. Birthplace: Westernport, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Leroy Newman Suter

FATHER — 13. Birthplace: Springfield, W.Va.

MOTHER — 14. Maiden name: Luella McCutcheon

MOTHER — 15. Birthplace: Martin, W.Va.

16. Informant: L.W. Suter

Address: Keyser, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 2/39 (month) (day) (year)

Cemetery or crematory: Knobley Cemetery

Location: near Martin, W.Va.

18. Funeral director: J.H. Markwood Sons

Address: Keyser, W.Va.

19. Nov. 1 (Date rec'd by registrar) 19 39 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 1, 19 39, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 1, 19 39, to Nov 1, 19 39

and that I last saw h-ee alive on Nov 1, 19 39

Immediate cause of death: Congenital Heart defomable — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury — Injured at work?

23. SIGNATURE: Lee Reeves M.D.
M. D. or other

Address: Westernport Md Date signed 11/1/39

RECEIVED
DEC 4 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

10658

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH: ALLEGANY COUNTY

County

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 20 Days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 415 RACE ST.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
JEROME P. SWARTLEY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife Anna V. Rohrer

6(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) JAN. 29, 1864

8. AGE: Years	Months	Days	If less than one day
75	9	28	hrs. min.

9. Birthplace PENNA.
(Town, county, and state)

10. Usual occupation Retired Conductor

11. Industry or business Railroad,

FATHER 12. Name AARON SWARTLEY

13. Birthplace Edmyer, Penna

MOTHER 14. Maiden name MARY ?

15. Birthplace Unknown

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 29 39 (month) (day) (year)

Cemetery or crematory Rose Hill Cems.

Location Cumberland Md.

18. Funeral director Lomis Stein Inc.

Address Cumberland

19. Nov. 29, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 27, 1939 @ 11:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 7 1939, to Nov. 27, 1939, and that I last saw him alive on Nov. 27 1939.

Immediate cause of death	DURATION
Pneumonia	?
Due to Chronic Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other

Address Cumberland Date signed 11/27/39

DR. W. F. WILLIAMS

RECEIVED
DEC 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-a)

10659

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, ~~hospital, or institution~~: 603 Patterson Ave

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) — 14 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 603 Patterson Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Mrs Mary C. Thomas

3. (b) Social Security Number

4. Sex F

5. Color or race White

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Wm H. (Deceased)

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 21, 1850

8. AGE: Years 89 Months 6 Days 7 If less than one day ____ hrs. ____ min.

9. Birthplace Sgh. Penna
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Peter Walker
13. Birthplace England

MOTHER
14. Maiden name Elizabeth Ferrel
15. Birthplace England

16. Informant Mrs D. M. Graham (Daughter
Address Cumberland, Md

17. Burial + Removal Date thereof Nov 30-39
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or ~~crematory~~ South Side Cem.

Location Pittsburgh, Penna

16. Funeral director V. L. Temperam

Address Cumberland, Md.

19. Nov. 28 1939 J. P. Franklin, M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1939, at 3:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 27 1939, to November 28 1939, and that I last saw her alive on November 27, 1939 1939.

Immediate cause of death Uremia.

Due to Constrictive Vascular Renal Disease.

Due to Senility.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION
20 hrs
Years

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. M. Schindler M.D.
M. D. or other

Address 41 Greenwich Date signed Nov 28 1939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1939
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

10660

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany

City or town Westernport

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Reeves Clinic

Stay in hospital or inst. (yrs., or mos., or days) 6 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Westernport Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. S Spruce St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Eva Elsie Tichnell.

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife James Tichnell

6(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1905

8. AGE: Years 33 | Months 10 | Days 25 | If less than one day ___ hrs. ___ min.

9. Birthplace Pettit, Tucker - W. Va (Town, county, and state)

10. Usual occupation House - wife

11. Industry or business

FATHER 12. Name Virgil Hartman

13. Birthplace Radia, W. Va

MOTHER 14. Maiden name Buena Loughry

15. Birthplace Parsons, W. Va

16. Informant James Tichnell

Address Westernport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 26-1939 (month) (day) (year)

Cemetery or crematory Tichnell Cemetery

Location 7 miles West Bloomington Md.

18. Funeral director D. S. Beall

Address Westernport, Md.

19. Nov. 24 1939 (Date rec'd by registrar) A. Sayenbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1939, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1939, to Nov. 23 1939, and that I last saw her alive on Nov. 23 1939.

Immediate cause of death Chr. Myocarditis Secondary arteriosis — DURATION ?

Due to

Due to

Other conditions Chronic Nephritis — ?

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. W. Reeves M.D. M. D. or other

Address Westernport Date signed 11/24/39

RECEIVED
DEC 4 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 211-m

10661

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany County

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 2 hours

Stay in this community (yrs., or mos., or days): 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Mineral

City or town: Pattersons Creek Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Dewey Leroy Troutman

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 5, 1924

8. AGE: Years 15 | Months 4 | Days 11 | If less than one day ____ hrs. ____ min.

9. Birthplace: West Virginia, Fort Ashby
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER
12. Name: Dewey Troutman
13. Birthplace: ~~Maryland~~ Fort Ashby W. Va.

MOTHER
14. Maiden name: Minerva Fisher
15. Birthplace: Maryland, Hagerstown

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 18, 1939 (month) (day) (year)

Cemetery or crematory: Fort Ashby

Location: Fort Ashby, W. Va.

18. Funeral director: Jacob Hofer
Address: Cumberland

19. Nov. 18, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15, 1939, at 2:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1939, to Nov 15 1939, and that I last saw him alive on Nov 15 1939.

Immediate cause of death: Fractured skull — DURATION: 2 hrs

Due to: Motorcycle

Due to: accident

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations: none
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 11-15-39

Where did injury occur: near Cumberland (City or town) Allegany (County) Md (State)

Injured at home, farm, industry, public place (where?): on road

Means of injury: motorcycle Injured at work?

23. SIGNATURE: F. M. Wilson, M.D. M. D. or other

Address: Cumberland, Md Date signed: 11-17-39

DR. F. WILSON

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 6 1939
BUREAU V. S.

10662

STATE OF MARYLAND
CERTIFICATE OF DEATH

(159)

Registration Dist. No. 8

[1]PLACE OF DEATH

County Allegany

Village or City Lonacoming (No. ____ St.: ____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

[2]FULL NAME — Watkinson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Nov 20, 1939 (Month) (Day) (Year)

7 AGE: ____ yrs. ____ mos. ____ ds. If LESS than 1 day 2 hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed or (employer): —

9 BIRTHPLACE (State or country): Lonacoming, Md

PARENTS

10 NAME OF FATHER: Joseph Lester Watkinson

11 BIRTHPLACE OF FATHER (State or country): Lonacoming, Md

12 MAIDEN NAME OF MOTHER: Mary Frances Bostgomer

13 BIRTHPLACE OF MOTHER (State or Country): Nikep, Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lester Watkinson

(Address) Lonacoming, Md

15 Filed Nov. 21, 1939 Dr. E. Ora Taylor Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov 20, 1939 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from ____ 192__ to ____, 192__, that I last saw h ____ alive on Nov 20, 1939, and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH * was as follows:

Premature birth

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Henry M. Hodgson M. D.

Nov. 21 1939 (Address) Lonacoming, Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Laurel Hill Cemetery

DATE OF BURIAL: Nov. 21, 1939

20 UNDERTAKER: M. Eichhorn

ADDRESS: Lonacoming

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V S No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia,*" "PUERPERAL *peritonitis,*" *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

RECEIVED DEC 7 1920

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131)

CERTIFICATE OF DEATH

10663

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany County
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days): 8 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Westernport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Allen Westfall

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife: None
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 12, 1922

8. AGE: Years	Months	Days	If less than one day
17	2	5	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: At home
11. Industry or business

FATHER
12. Name: Ernest Westfall
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Nellie Wilt
15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 19 1939 (month) (day) (year)
Cemetery or crematory: Bloomington, Md.
Location: Garrett County
16. Funeral director: D. S. Boor Jr.
Address: Westernport, Md.

19 Nov. 19 (Date rec'd by registrar) 19 39 J. H. Franklin, M.D. Registrar

DR. W.F. & R. WILLIAMS

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1939 at 4:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/2/39 19 to 11/17/39 19, and that I last saw h alive on 11/17/39 19.

Immediate cause of death	DURATION
Pneumonia	
Chronic Nephritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Richard D. Williams, M.D. M. D. or other
Address 34 Main Ave. Date signed 11/17/39

RECEIVED
DEC 6 1939
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (158)

10664

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 11 Bowery St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 4 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Alleg

City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 11 Bowery St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Ronald Jessie White

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Infant

B (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Nov 14 1939

8. AGE: Years | Months | Days: 3 1/2 | If less than one day ____ hrs. ____ min.

9. Birthplace: Frostburg Md
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: Ivan White
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Viola Short
15. Birthplace: Borden Mines Md

16. Informant: Ivan White
Address: Frostburg Md

17. ____ (Burial, cremation, or removal. Which?) Date thereof: 11-18-39 (month) (day) (year)

Cemetery or crematory: Porter

Location: Eckhart Md

18. Funeral director: Ivan White Parent

Address: Bowery St Frostburg, Md

19. 11-18 1939 (Date rec'd by registrar) Mrs A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 18 1939, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 14 1939, to Nov 18 1939, and that I last saw him alive on Nov 17 1939.

Immediate cause of death: Congenital debility — DURATION: 3 1/2 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: W. M. Lane Jr. M.D.
M. D. or other

Address: Frostburg Md Date signed: Nov 18 1939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 2 1939
BUREAU V. S.

Outside of City Limits

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (151)

CERTIFICATE OF DEATH

10665

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Route # 3

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 4 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany.

City or town Rural near Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Route # 3.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Wm. Harrison Wilkins

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed.

6 (b) Name of husband or wife Barbara Colledge

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept 9, 1869

8. AGE: Years	Months	Days	If less than one day
70	2	6	____ hrs. ____ min.

9. Birthplace Dudley, Bedford Co., Pa. (Town, county, and state)

10. Usual occupation Coal Miner

11. Industry or business Coal Mines.

FATHER 12. Name Joseph Wilkins

13. Birthplace Unknown

MOTHER 14. Maiden name ? Reed.

15. Birthplace Unknown.

16. Informant Robert Wilkins

Address R7D# 1, Hyndman, Pa.

17. Burial Date thereof Nov 19, 1939.

(Burial, cremation, or removal) (Which?) (month) (day) (year)

Cemetery or crematory Hopewell Cem.

Location Hopewell, Pa

18. Funeral director Jacob Hafer

Address Cumberland, Md.

19 Nov. 17, 1939 J. P. Franklin, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1939, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 in 1939, to Nov 15 1939, and that I last saw h[illegible] alive on Nov. 12 1939.

Immediate cause of death	DURATION
Chronic Endocarditis	7 yrs
Due to Chronic Nephritis	7 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. H. Franklin M. D. or Other

Address Cumberland Md Date signed Nov 17 39

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DEC 6 1939
BUREAU V. S.

10666

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

WITHIN CORPORATE LIMITS

93-C

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 8 Mill St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 8 Mill Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: World War

3. (a) FULL NAME: Richard Williams

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 7/30/91

8. AGE:

Years	Months	Days	If less than one day
48	3	7	____ hrs. ____ min.

9. Birthplace: Carlos - Maryland - Allegany
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business

FATHER
12. Name: Henry Williams
13. Birthplace: Wales

MOTHER
14. Maiden name: Jean Pollock
15. Birthplace: Scotland

16. Informant: Mrs Wm. Thomas

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 9 1939 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg, Md.

18. Funeral director: J. J. Durst

Address: Frostburg, Md

19 Nov. 9th 1939 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6th., 1939, at about 1P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death: Chronic Myocarditis

Due to

Due to

Other conditions: Chronic Alcoholism
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy: no autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Levine Carson Pierce H. Carson, M.D.
M. D. or other

Address: Cumberland, Maryland Date signed: 11/7/1939

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (2)

Reg. Dist. No. 9 — 10667

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Miners Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in this community (yrs., mos., or days) —

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State — (b) County —
(c) City or town — (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) **FULL NAME** Baby Winebrenner.

3 (b) If veteran, name war —
3 (c) Social Security No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 2 1939

8. AGE: Years | Months | Days | If less than one day: Stillborn hr. — min.

9. Birthplace Frostburg Md (Town, county, and state)

10. Usual occupation Stillborn

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name Helen Mary Winebrenner
15. Birthplace Near Frostburg

16 (a) Informant Helen Mary Winebrenner
(b) Address Frostburg Md

17 (a) — (Burial, cremation, or removal) (b) Date thereof (month) Nov. (day) 2 (year) 39
(c) Cemetery or crematory —
Location Frostburg Md

18 (a) Funeral director Carl Miller
(b) Address E. Main St. Frostburg Md

19 (a) 11-2-39 (Date rec'd by registrar) (b) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death Nov 2 1939, at 9 00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Stillborn 19—, to 19—, and that I last saw him alive on 19—.

Immediate cause of death	Duration
Death of Foetus in Utero	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Wm McLane Jr MD (M. D. or other)
Address Frostburg Md. Date signed Nov 2 1939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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WITHIN CORPORATE LIMITS

M

10668

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (67)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 428 Walnut St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 428 Walnut St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Richard Lawarence Wotring

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20 - 39

8. AGE: Years | Months | Days 23 | If less than one day hrs. min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Richard Wotring
13. Birthplace Md

MOTHER
14. Maiden name Bertha Bennett
15. Birthplace Penna

16. Informant Richard Wotring
Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 15 - 39 (month) (day) (year)

Cemetery or crematory Hillcrest Ceme

Location Cumberland Md.

18. Funeral director V. L. Lemperans
Address Cumberland, Md.

19. Nov. 15, 1939 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1939, at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 20, 1939, to Nov. 13, 1939, and that I last saw him alive on Nov. 9, 1939.

Immediate cause of death: Status Lymphaticus (Sudden Death)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay E. Burrett M. D. or other

Address Cumberland, Md Date signed Nov. 15, 1939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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